Supreme Court, U.S.
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No.

In The

Supreme Court of the United States

October Term, 1996

ARROWWEST PHYSICIAN ASSOCIATION,

Petitioner,

vs.

WILLIAM ARDARY, *et al.*,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether state law actions challenging Medicare benefits determinations and seeking consequential damages for denial of Medicare benefits are precluded by the Medicare Act, which requires any individual dissatisfied with a Medicare benefits determination to exhaust the administrative remedies prescribed by the Medicare Act.

PARTIES TO THE PROCEEDING

Petitioner Arrowwest Physician Association ("Arrowwest") was one of the appellees in the Court of Appeals. Arrowwest has no parent or subsidiary companies.[1]

Respondents Aetna Health Plans of California, Inc., Aetna Life Insurance Company, AHP Holdings, Inc., Aetna Health Management, Inc. and Judith Hendrix (collectively "Aetna") also were appellees in the Court of Appeals, and have filed their own Petition for Writ of Certiorari.

Respondents William Ardary, Diane M. Houston, Kevin Ardary, and William C. Ardary, M.D. were the appellants below. They are the surviving family members of Cynthia Ardary, a Medicare beneficiary whose claim for benefits gave rise to this action.

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1. Arrowwest changed its name to Inland Healthcare Group, a Medical Corporation, on January 31, 1995. However, since the group was sued in this action as Arrowwest, petitioner will continue to refer to itself by that name in all papers submitted to this Court.

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Arrowwest respectfully petitions for a writ of *certiorari* to review the judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit, as amended on denial of rehearing and rehearing *en banc*, is reported as 98 F.3d 496 (1996), and is reprinted in Appendix A.

The unpublished opinion of the United States District Court for the Central District of California is reprinted in Appendix B.

STATEMENT OF JURISDICTION

The judgment of the United States Court of Appeals for the Ninth Circuit was entered on October 21, 1996. Petitioner Arrowwest timely filed a Petition for Rehearing with Suggestion for Rehearing *En Banc*, and respondent Aetna timely filed a Petition for Rehearing and Suggestion for Rehearing *En Banc*, which were denied on December 26, 1996. At that same time, the Court of Appeals amended its October 21, 1996 opinion. This Court has jurisdiction to entertain this petition pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

The Medicare Act provides for judicial review of Medicare determinations only under limited circumstances. 42 U.S.C. § 405(g) provides, in pertinent part:

> Any individual, after any final decision of the Commissioner of Social Security made

> after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia.

42 U.S.C. § 405(g) is expressly incorporated into Subchapter XVIII of the Medicare Act, entitled "Health Insurance for the Aged and Disabled," by 42 U.S.C. § 1395ff, which states in pertinent part:

> (a) **Entitlement to and amount of benefits**
>
> The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A or part B of this subchapter, and any other determination with respect to a claim for benefits under part A of this subchapter or a claim for benefits with respect to home health services under part B of this subchapter shall be made by the Secretary in accordance with regulations prescribed by him.

> **(b) Appeal by individuals; provider representation of beneficiaries**
>
> (1) Any individual dissatisfied with any determination under subsection (a) of this section as to —
>
> * * *
>
> (C) the amount of benefits under part A or B of this subchapter (including a determination where such amount is determined to be zero)
>
> * * *
>
> shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title, except that in so applying such sections . . . , any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

In addition, 1395mm(c)(5)(B) specifically incorporates 42 U.S.C. § 405(g) into the statutory provisions dealing with Medicare Health Maintenance Organizations "HMOs"). That section provides in pertinent part:

> A member enrolled with an eligible organization under this section who is dissatisfied by reasons of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the eligible organization a party. If the amount in controversy is $1,000 or more, the individual or eligible organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 405(g) of this title, and both the individual and the eligible organization shall be entitled to be parties to that judicial review. In applying sections 405(b) and 405(g) of this title as provided in this subparagraph, . . . any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

The jurisdictional bar of 42 U.S.C. § 405(h) provides in pertinent part:

> The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings

> of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as provided herein. No action against the United States, the Commissioner of Social Security or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover any claim arising under this subchapter.

42 U.S.C. § 405(h) is expressly incorporated into Subchapter XVIII of the Medicare Act by 42 U.S.C. § 1395ii, which states in pertinent part:

> The provisions of . . . subsections (a), (d), (e), (h), (i), (j), (k), and (l) of subsection 405 of the title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II, except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

The regulations implementing the above-cited statutory provisions expressly provide that the jurisdictional limitations and exhaustion-of-remedies requirement apply to denials of benefits for emergency services (such as the airlift transfer at issue in this case), and to challenges to denials of benefits brought by representatives of deceased enrollees. Specifically, 42 C.F.R. § 417.606(a) states in pertinent part:

> An organization determination [*i.e.*, an HMO benefits determination that is subject to administrative appeal by the beneficiary] is any determination made by an HMO or CMP with respect to any of the following: [¶] (1) Payment for emergency or urgently needed services.

42 C.F.R. § 417.610 states in pertinent part:

> The parties to the organization determination are — . . . [¶] (c) The legal representative of a deceased enrollee's estate[.]

STATEMENT OF THE CASE

Arrowwest hereby adopts and incorporates herein by reference the Statement of the Case set forth in the separate Petition for Writ of Certiorari filed by Aetna ("Aetna's Petition") at 3-6. Arrowwest also wishes to furnish the Court with the following additional information regarding Arrowwest's role in this litigation. Arrowwest is an incorporated group of physicians that contracts with Aetna to provide health care services to enrollees of Aetna's Medicare HMO. Thus, when Cynthia Ardary was brought to the emergency department at Bear Valley Community Hospital after suffering a heart attack, it was an Arrowwest cardiologist — acting as Aetna and Medicare's agent — who made the medical determination that Cynthia Ardary could not be transferred by helicopter from Bear Valley Community Hospital to Loma Linda University Medical Center, and who therefore denied authorization for such a transfer to be covered as a benefit of the Aetna Medicare HMO plan in which Cynthia Ardary was enrolled. Arrowwest is the co-defendant referred to in Aetna's petition as having joined Aetna in removing the state court action to the federal district court. *See* Aetna's

Petition at 4. Arrowwest filed a Petition for Rehearing with Suggestion for Rehearing *En Banc* on November 4, 1996, and it was denied on December 26, 1996.

REASONS FOR GRANTING THE WRIT

Arrowwest hereby adopts and incorporates herein by reference the Reasons for Granting the Writ set forth in Aetna's Petition at 7-21. In addition, Arrowwest respectfully submits the following additional arguments regarding the enormous national significance of the issue presented by this petition and, therefore, the compelling need for this Court to grant review of the instant case.

Managed care — whatever its virtues and vices — ***is*** the future of health care in this country. Both the federal Medicare program and the joint federal-state Medicaid program are pushing to enroll as many beneficiaries as possible, as quickly as possible, in managed care plans so that they can attempt to contain spiraling health care costs. Medicare HMO enrollment grew by 25% in 1994, by 36% in 1995, and by 33% in 1996. Prepared Statement of Bruce Vladek, Ph.D., Administrator of the Health Care Financing Administration, before the Senate Finance Committee on "Medicare Managed Care," Federal News Service, March 19, 1997. Medicare beneficiaries are currently enrolling in managed care plans at the rate of ***80,000 per month***. *Washington Health Week*, No. 5, Vol. 5, Atlantic Information Services, Inc., February 3, 1997. According to a recent Congressional press release, the number of Medicare beneficiaries enrolled in HMOs has tripled since 1991, and the Congressional Budget Office predicts that more than one-third of all Medicare beneficiaries will be enrolled in such plans by 2007. "Thomas Announces Hearing on Medicare HMO Regulation," Congressional Press Release, Federal Document Clearing House, February 25, 1997. While there currently are

33 million Americans over the age of 65, in the next century that number will grow to ***more than 77 million***. Prepared Testimony of J. Michael McGinnis, M.D., Member, Partnership for Prevention Board of Directors, before the House Ways and Means Committee Health Subcommittee, Federal News Service, March 13, 1997. Thus, the number of people potentially affected by the decision in this case is huge.

Allowing Medicare beneficiaries to bypass the Medicare administrative appeals process and sue over benefits denials in state court, merely by alleging consequential damages (such as emotional distress), is a prescription for administrative and financial chaos in the Medicare program, at odds with the language and purpose of the Medicare Act and prior decisions of this Court and others, as outlined in Aetna's Petition. Uniformity of decision will become impossible. The ability of the Department of Health and Human Services to contract with HMOs to provide services to Medicare beneficiaries will be severely undermined, because many HMOs may be unwilling to accept such business if they can be sued over every Medicare benefit denial. Moreover, the cost savings achieved by the Medicare HMO system will be consumed entirely by the cost of litigation (and indeed, that cost may far exceed the savings attained through avoiding the provision of unnecessary care — the *raison d'être* of managed care). Such a result will only harm the millions of present and future beneficiaries (and their families) who expect the Medicare program to pay for their health care.

CONCLUSION

For all the foregoing reasons, the Petition for Writ of *Certiorari* should be granted.

Respectfully submitted,

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT
No. 94-56552

William Ardary; Diane M. Houston;
Kevin Ardary; William C. Ardary, MD,
Plaintiffs-Appellants,

v.

Aetna Health Plans of California, Inc., formerly dba:
Aetna Health Plans of Southern California, Inc.;
Aetna Life & Casualty Company; Aetna Life Insurance
Company; AHP Holdings, Inc.; Aetna Health Management,
Inc.; Partners Acquisition Company; Arrowest Physician
Association; Judith Hendrix,
Defendants-Appellees.

Argued and Submitted April 10, 1996.
Decided Oct. 21, 1996.
As Amended on Denial of Rehearing and
Rehearing En Banc Dec. 26, 1996.

Before: O'SCANNLAIN and TROTT, Circuit Judges, and VAN SICKLE, Senior United States District Judge for the District of North Dakota, sitting by designation.

O'SCANNLAIN, Circuit Judge:

We must decide whether state law claims for wrongful death against a private Medicare provider are preempted by the Medicare Act.

I

William Ardary, Kevin Ardary, William C. Ardary, and Diane M. Houston ("the Ardarys") are the surviving husband and children of the late Cynthia Ardary. In July 1991, William and Cynthia attended a presentation given by Judith Hendrix ("Hendrix"), a marketing representative of Aetna Health Plans of California.[1] Because William and Cynthia resided in the relatively isolated community of Big Bear, California, they expressed concern to Hendrix about emergency care and the availability of more sophisticated treatment. Hendrix allegedly told William and Cynthia that should the need arise, Aetna would immediately authorize transfer to a larger facility such as Loma Linda University Medical Center. As a result of Hendrix's presentation, Cynthia, a Medicare beneficiary, enrolled in Aetna's Senior Choice health maintenance organization plan ("Plan"). The Plan was administered by Arrowest Physician Association ("Arrowest") and provided Medicare, major medical and hospitalization, benefits pursuant to a contract with the U.S. Department of Health and Human Services, Health Care Financing Administration ("HCFA").

On May 9, 1993, Cynthia suffered a heart attack. She was taken to the Bear Valley Community Hospital, a small rural facility near her family's home. The hospital had neither intensive nor cardiac care facilities. The Ardarys allege that in spite of repeated requests from her Aetna-approved physician,

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[1] Aetna Health Plans of California, Inc., formerly dba Aetna Health Care Plans of Southern California, Inc., Aetna Life and Casualty Company, Aetna Life Insurance Company, AHP Holdings, Inc., Aetna Health Management, Inc., Partners Acquisition Company, and Judith Hendrix are collectively referred to herein as "Aetna."

Arrowest refused to authorize airlift transportation for Cynthia to Loma Linda University Medical Center.[2] Allegedly because of Arrowest's failure to authorize the airlift, Cynthia died at Bear Valley.

On January 25, 1994, Cynthia's husband and children filed a wrongful death complaint against Aetna and Arrowest in California state court seeking general and punitive damages on the basis of six state law theories of recovery including negligence, intentional and/or negligent infliction of emotional distress, intentional and/or negligent misrepresentation, and professional negligence.[3] The complaint did not seek recovery

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2 At oral argument, Arrowest claimed that they could not certify the transfer under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C.A. s 1395dd. EMTALA imposes two requirements on any hospital which participates in the Medicare program: the hospital must conduct appropriate medical screening to a person visiting its emergency room, and a hospital generally may not transfer out of hospital patient whose medical condition has not been stabilized. Brewer By and Through Brewer v. Miami County Hosp., 862 F.Supp. 305 (D.Kan.1994). Whether Cynthia Ardary was stabilized is, of course, a question of fact.

3 The complaint alleges a cause of action against: (1) Aetna, Arrowest and Hendrix for negligence; (2) Aetna and Arrowest for intentional infliction of emotional distress; (3) Aetna and Arrowest for negligent infliction of emotional distress; (4) Aetna and Hendrix for intentional misrepresentation; (5) Aetna and Hendrix for negligent misrepresentation;

(continued...)

of Medicare benefits; however, the Ardarys conceded that their claims were all "predicated on" Arrowest's failure to authorize the airlift.[4]

In February 1994, Aetna and Arrowest timely removed the action to federal court. They argued that removal was proper on the grounds that federal- question jurisdiction existed because the Ardarys' claims all related to the denial of Medicare benefits and therefore were preempted by federal law. Once in federal court, however, Aetna and Arrowest moved to dismiss the complaint under Fed.R.Civ.P. 12(b)(1) and 12(b)(6) for failure to state a claim, on the ground that the Ardarys' exclusive remedy for their action "relating to" the denial of Medicare benefits was the administrative appeals process provided by HCFA. The district court granted the motion to dismiss in a one-page order that provided no reasons for the court's decision. The Ardarys timely appealed.

II

We first consider the Ardarys' argument that the district court erred in finding that the state law claims all related to the denial of Medicare benefits and therefore were preempted by

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[3](...continued)
and (6) Hendrix for professional negligence. Complaint ¶¶ 23-100.

[4] "It is critical to note in this context that the wrongful death action is predicated on the allegation that the benefits were, in fact, owed and were, in fact, wrongfully denied. Moreover, the plaintiffs in such an action will also be required to demonstrate, at trial, that the wrongful denial of benefits was the proximate cause of the death." Appellant's Brief at 20-21.

the Medicare Act, 42 U.S.C. s 1395, with such claims exclusively administered and reviewed by HCFA.

A

The Medicare Act ("Act") is found in Part A of Title XVIII of the Social Security Act, 42 U.S.C. s 1395 et seq. The Act provides insurance for the cost of hospital and related post-hospital expenses, but precludes reimbursement for services which are not "reasonable and necessary" for the diagnosis or treatment of illness or injury.

Section 405(g) of Title 42, which falls within a different section of the Social Security Act, provides for judicial review of old-age and disability claims only after the Secretary of Health and Human Services renders a "final decision" on the claim.[5] Pursuant to 42 U.S.C. s 1395ff(b), this provision is expressly incorporated into those portions of the Act which apply to HMOs. Pursuant to her rulemaking authority, the

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[5] Section 405(g) reads in relevant part: Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides.... The court shall have power to enter ... a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. 42 U.S.C. § 405(g).

Secretary has provided that a "final decision" is rendered on a Medicare claim only after the individual claimant has pressed his claim through all designated levels of administrative review.[6]

In addition, even when judicial review is available it is strictly limited. Section 1395ii of Title 42 applies the proscriptions of 42 U.S.C. s 405(h) to the Act. Section 405(h) states as follows: The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this

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[6] The exclusive administrative appeals process applies to all benefits determinations. 42 U.S.C. § 405(b); 1395mm(c)(5)(A); 42 C.F.R. § 417.606. Such disputes must first be brought for reconsideration to the organization that made the initial determination, 42 C.F.R. § 417.616 and 417.620, and HCFA. 42 C.F.R. § 417.620. If the dispute is not resolved favorably by HCFA, and providing the amount in controversy exceeds $100, a hearing may be requested before an administrative law judge. 42 C.F.R. § 417.630, 417.632. A further appeal may be made to the agency's Appeals Council and, should the amount in controversy exceed $1,000, a dissatisfied party may thereafter seek review in federal court. 42 C.F.R. §§ 417.634, 417.636.

subchapter. 42 U.S.C. s 405(h) (emphasis added).[7] Discussing this provision, the Supreme Court of the United States has held that the appropriate inquiry in determining whether s 405(h) bars federal-question jurisdiction must be whether the claim "arises under" the Act. The Court stated that

> [t]he third sentence of 42 U.S.C. s 405(h), made applicable to the Medicare Act by 42 U.S.C. s 1395ii, provides that s 405(g), to the exclusion of 28 U.S.C. s 1331, is the sole avenue for judicial review of all "claim[s] arising under" the Medicare Act. Thus, to be true to the language of the statute, the inquiry in determining whether s 405(h) bars federal-question jurisdiction must be whether the claim "arises under" the Act.... Heckler v. Ringer, 466 U.S. 602, 614-15, 104 S.Ct. 2013, 2021, 80 L.Ed.2d 622 (1984) (internal citations omitted).

B

This case presents a thorny jurisdictional question: does the Medicare Act, which provides for exclusive administrative review of all claims "arising under" that Act, apply to preclude the heirs of a deceased Medicare beneficiary from bringing state law claims for wrongful death against a private Medicare provider when those claims do not seek recovery of Medicare benefits but instead seek compensatory and punitive damages on the grounds that the provider both improperly denied emergency

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[7] Section 405(h) thus makes § 405(g) the sole avenue for judicial review of all "claim[s] arising under" the Medicare Act.

medical services and misrepresented its managed care plan to the beneficiary?[8]

Resolution of this question turns on whether the state law claims are ones "arising under" the Act. Aetna and Arrowest argue that the entire complaint "arises under" the Act because the Ardarys' claims all relate to a dispute concerning the denial of Medicare benefits.[9] Aetna and Arrowest also maintain that "[t]he courts similarly left no doubt that the Medicare Act precludes all types of civil litigation outside the administrative appeals process" in this case. Appellee's Brief at 12. We disagree with this over-inclusive reading of the "arising under" language.

First, the Ardarys' complaint does not "include any claims in which 'both the standing and the substantive basis for the presentation' of the claims" is the Act. Heckler v. Ringer, 466 U.S. 602, 615, 104 S.Ct. 2013, 2021-22, 80 L.Ed.2d 622 (1984) (citing Weinberger v. Salfi, 422 U.S. 749, 760-61, 95 S.Ct. 2457, 2464-65, 45 L.Ed.2d 522 (1975)) (emphasis added). The Ardarys seek general and punitive damages on the basis of negligence, intentional and/or negligent infliction of emotional distress, intentional and/or negligent misrepresentation, and professional negligence. The standing for these six claims are state common law theories and not the Act. Second, the state law claims are not "inextricably

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[8] The parties do not cite any cases directly addressing the question raised in this case.

[9] Aetna and Arrowest frame the issue as "whether Congress intended to allow the state court actions challenging Medicare benefits determinations when it barred such actions in federal court." Appellee's Brief at 12.

intertwined" with the denial of benefits. Although the Ardarys concede that their wrongful death complaint is "predicated on" Arrowest's failure to authorize the airlift transfer, the claims are not "inextricably intertwined" because the Ardarys are at bottom not seeking to recover benefits. Ringer, 466 U.S. at 614, 104 S.Ct. at 2021. In contrast, the Court in Ringer observed that [i]t seems to us that it makes no sense to construe the claims of those three respondents as anything more than, at bottom, a claim that they should be paid for their BCBR surgery. Arguably respondents do assert objections to the Secretary's "procedure" for reaching her decision--for example, they challenge her decision to issue a generally applicable rule rather than to allow individual adjudication, and they challenge her alleged failure to comply with the rulemaking requirements of the APA in issuing the instructions and the rule. We agree with the District Court, however, that those claims are "inextricably intertwined " with respondents' claim for benefits. Id. (emphasis added).

Although the Supreme Court in Ringer instructed us to read the term "arising under" broadly, it "recognized that in certain special cases, deference to the Secretary's conclusion as to the utility of pursuing the claim through administrative channels is not always appropriate." Id. at 618, 104 S.Ct. at 2023. For instance, the Court commented on one such case, "where the plaintiff asserted a procedural challenge to the Secretary's denial of a pretermination hearing, a claim that was wholly 'collateral' to his claim for benefits, and where he made a colorable showing that his injury could not be remedied by the retroactive payment of benefits after exhaustion of his administrative remedies." Id. (citing Mathews v. Eldridge, 424 U.S. 319, 330-32, 96 S.Ct. 893, 900-01, 47 L.Ed.2d 18 (1976)). Aside from the conclusion that the Ardarys' state law tort claims are not "inextricably intertwined" with benefit determinations, Cynthia's death also cannot be remedied by the retroactive authorization or payment of the airlift transfer.

Aetna and Arrowest argue that Bodimetric Health Services, Inc. v. Aetna Life & Casualty, 903 F.2d 480 (7th Cir.), cert. denied, 498 U.S. 1012, 111 S.Ct. 579, 112 L.Ed.2d 584 (1990), should be read for the proposition that any claim related to the denial of Medicare benefits "arises under" the Act. In that case, Bodimetric Health Services owned and operated home health agencies ("HHAs") that provided in-home medical services. All of the HHAs were certified as Medicare providers which obtained their reimbursements for the medical services from fiscal intermediaries which acted on behalf of HCFA. Pursuant to 42 U.S.C. s 1395h, Bodimetric nominated Aetna to serve as its fiscal intermediary. Under this situation, Aetna provided Medicare reimbursement to Bodimetric's HHAs for services rendered.

Bodimetric alleged that in 1985, the Secretary released a contractor evaluation critical of Aetna's performance. Bodimetric alleged that because of this evaluation, Aetna started regularly to deny Bodimetric's applications for reimbursement so that Aetna would improve its contract performance evaluation and retain its contract with HCFA as a fiscal intermediary. Because of the denials, Bodimetric lost $8 million. Bodimetric then sued Aetna, seeking damages for fraud and other tort causes of action. Aetna moved to dismiss for lack of subject matter jurisdiction, alleging that the exclusive review provisions of the Act barred Bodimetric from pursuing its challenge in federal court, and the district court granted the motion. On appeal, the Seventh Circuit stated that the issue was "whether the allegedly improper application of 'exclusive' review mechanisms to Bodimetric's claim is actionable in the district court." Id. at 482.

The Seventh Circuit noted that "whether Bodimetric's claim for damages is inextricably intertwined with a claim for Medicare benefits or wholly collateral to such a claim (or somewhere in between) depends largely on whether this appeal

more closely resembles United States v. Erika, 456 U.S. 201 [102 S.Ct. 1650, 72 L.Ed.2d 12] (1982) or Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 [106 S.Ct. 2133, 90 L.Ed.2d 623] (1986)." Id. at 484. In Erika, "the Court held that section 1395ff barred judicial review of a hearing officer's 'amount of benefits' determination under Part B of the Medicare Act." Id. However, in Michigan Academy, "the Court concluded that section 1395ff does not bar judicial review of claimant challenges to the validity of administrative regulations promulgated under the Medicare Act." Id. We conclude that the Ardarys' state law claims do not fall under either of the two types of claims reviewed in Erika and Michigan Academy.

The Seventh Circuit concluded that "Erika and Michigan Academy recognized the differences between two types of Medicare claims: challenges to the amount of benefits to be paid are not reviewable, while challenges to the regulatory scheme under which the amount of benefits is calculated are reviewable." Id. at 485. Although the Seventh Circuit properly identified the "differences between two types of Medicare claims," the Supreme Court's decisions in Erika and Michigan Academy certainly do not suggest, at least to this court, that this dichotomy (substantive or procedural) is the standard for making the critical judgment call about what "arises under" the Act. It should be stressed that the Supreme Court has already rejected that "separation of the particular claims ... into 'substantive' and 'procedural' elements." Ringer, 466 U.S. at 614, 104 S.Ct. at 2021.

Without clear guidance from the Supreme Court or Congress on these facts, we must begin with the strong presumption that Congress does not intend to pre- empt state law causes of action with a federal statute. See, e.g., Medtronic, Inc. v. Lohr, — U.S. —- —-, 116 S.Ct. 2240, 2250, 135 L.Ed.2d 700 (1996) ("[B]ecause the States are

independent sovereigns in our federal system, we have long presumed that Congress does not cavalierly pre- empt state-law causes of action."); Cipollone v. Liggett Group, Inc., 505 U.S. 504, 516, 112 S.Ct. 2608, 2617, 120 L.Ed.2d 407 (1992) ("[S]tate law is pre-empted if the law actually conflicts with federal law."); Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230, 67 S.Ct. 1146, 1152, 91 L.Ed. 1447 (1947) ("[S]tart with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."). We find nothing in the legislative history to suggest that the Act was designed to abolish all state remedies which might exist against a private Medicare provider for torts committed during its administration of Medicare benefits pursuant to a contract with HCFA. See Michigan Academy, 476 U.S. at 679-80, 106 S.Ct. at 2140-41. Indeed, the "legislative history of both the statute establishing the Medicare program and the 1972 amendments thereto provides specific evidence of Congress' intent to foreclose review only of 'amount determinations'--i.e., those 'quite minor matters,' 118 Cong.Rec. 33992 (1972) (remarks of Sen. Bennett), remitted finally and exclusively to adjudication by private insurance carriers in a 'fair hearing.' " Michigan Academy, 476 U.S. at 680, 106 S.Ct. at 2141.

We are most reluctant to adopt Aetna and Arrowest's over-inclusive reading of the "arising under" language "without a showing of clear and convincing evidence to overcome the strong presumption that Congress did not mean to prohibit all judicial review." Id. (citations omitted). Absent a strong argument from Aetna and Arrowest, this presumption still remains in force.

Contrary to Aetna and Arrowest's assertions, Bodimetric should not be taken to imply that private Medicare providers and their representatives cannot be held responsible in their individual capacity for tortious acts committed in the context of

the denial of Medicare benefits. The removal of the right to sue the private Medicare provider for its torts would result in an inequitable and substantial dilution of the rights of patients. Aetna and Arrowest's argument that the claims are "inextricably intertwined" with the claim that Cynthia was improperly denied benefits simply misapplies Ringer and Bodimetric on these facts.

Because the instant state law claims do not "arise under" the Act, we hold that the exclusive administrative procedures outlined for resolution of benefit determinations do not preempt the Ardarys' complaint.

III

We next consider whether the district court erred in removing the action to federal court. The Medicare statutes, as applied to an HMO contract, do not, of course, contain a preemption provision. The Ardarys argue that the district court was without jurisdiction because there was no federal statutory preemption of their state law claims, and therefore no substantial federal question was raised. Because we hold that the Ardarys' state law claims do not "arise under" the Medicare Act, we must conclude that the action was improperly removed to federal court. Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 66, 107 S.Ct. 1542, 1547-48, 95 L.Ed.2d 55 (1987).

IV

For the foregoing reasons, the district court's judgment is reversed, and this case is remanded with instructions to the district court to remand the action to state court for further proceedings.

REVERSED and REMANDED with instructions.

APPENDIX B

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

WILLIAM ARDARY, ET AL.,	) CF 94-1235 JSL
	)
Plaintiffs,	) ORDER GRANTING
	) DEFENDANTS'
v.	) MOTION TO
	) DISMISS
AETNA HEALTH PLANS OF CALIFORNIA, INC., ET AL.,	)
	)
	)
Defendants.	)
	)
	)

The Motion of defendants Aetna Health Plans of California, Inc., et al. to dismiss came for hearing regularly on March 28, 1994.

Having reviewed the papers filed in connection with this matter, having heard oral argument, and being fully apprised of the relevant facts and law,

IT IS HEREBY ORDERED that the motion of defendants Aetna Health Plans of California, Inc., et al. be GRANTED.

IT IS SO ORDERED.

DATED: 5/23/94

/s/
J. Spencer Letts
United States District Judge

APPENDIX C

NOT FOR PUBLICATION
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

WILLIAM ARDARY; DIANE M. HOUSTON; KEVIN ARDARY; WILLIAM C. ARDARY, MD, Plaintiffs-Appellants,	)	No. 94-56552 D.C. No. CV-94-01235-JSL
v.	)	
AETNA HEALTH PLANS OF CALIFORNIA, INC., formerly dba: AETNA HEALTH PLANS OF SOUTHERN CALIFORNIA, INC.; AETNA LIFE & CASUALTY COMPANY; AETNA LIFE INSURANCE COMPANY; AHP HOLDINGS, INC.; AETNA HEALTH MANAGEMENT, INC; PARTNERS ACQUISITION COMPANY; ARROWEST PHYSICIAN ASSOCIATION; JUDITH HENDRIX, Defendants-Appellees.	)	ORDER

Before: O'SCANNLAIN, Circuit Judge:

Appellee's motion for stay of mandate pending petition for certiorari to the Supreme Court of the United States is GRANTED pursuant to Fed. R. App. P. 41(b).

Supreme Court, U.S.
FILED
APR 29 1997
CLERK

Nos. 96-1377 & 96-1526

In The

Supreme Court of the United States

October Term, 1996

AETNA HEALTH PLANS OF CALIFORNIA, INC., *et al.*,

Petitioners,

-and-

INLAND HEALTHCARE GROUP/ARROWWEST PHYSICIANS ASSOCIATION,

Petitioner,

vs.

WILLIAM ARDARY, *et al.*,

Respondents.

On Petitions for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether a state law tort action seeking wrongful death damages based on negligence and misrepresentation — but not seeking payment of Medicare benefits — is preempted by the federal Medicare Act's administrative remedies requirements.

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Respondents William Ardary, Diane M. Houston, Kevin Ardary and William C. Ardary, M.D. respectfully submit this brief in opposition to the petitions for writ of certiorari seeking review of the decision of the United States Court of Appeals for the Ninth Circuit. The decision is reported at 98 F.3d 496 (1996) and is reprinted in both petitions at Appendix A.

STATEMENT OF THE CASE

The petitions seeking this Court's review misstate the issue, ignore pertinent facts, misrepresent the existence of a conflict among the circuits, and attempt to impose an unreasonably overbroad preemptive effect of the Medicare administrative review provisions. The petitions should be denied.

A. Summary of Material Facts

Respondents are the surving husband and children of Cynthia Ardary ("Cynthia"). Cynthia was a participant in and a beneficiary of the Aetna Senior Choice health maintenance organization plan. Petitioners' Appendices at 2a.[1]

Cynthia and her husband, respondent William Ardary, enrolled in Aetna's Senior Choice plan after attending a presentation made by petitioner Judith Hendrix in July, 1991 and sponsored by Aetna Health Plans of Southern California. *Id.* Cynthia and her husband resided in the geographically-isolated mountain community of Big Bear, California and, naturally, were concerned about the level of care which would be afforded to them as members of Aetna's health plan. *Id.* When the Ardarys questioned Aetna's representative, petitioner

---

1. Both petitions included the Ninth Circuit's opinion in their respective appendices, with identical page numbering. All subsequent references will be to either petition's Appendix as "App."

Hendrix, about emergency care and the need for more sophisticated treatment than the tiny Bear Valley Community Hospital could provide, they were told by Hendrix that — should the need arise — Aetna would immediately authorize transfer to a larger facility such as Loma Linda University Medical Center. *Id.* As a result of the presentation by Aetna's marketing representive, the Ardarys enrolled in Aetna's Senior Choice plan on or about July 1, 1991. *Id.*

In the early morning hours of May 9, 1993, Cynthia suffered a mild heart attack and was taken to Bear Valley Community Hospital, a small hospital with no intensive care unit or cardiac care unit, which was essentially equipped to treat only minor illnesses and ski injuries. *Id.*

At the hospital, Cynthia, who was in serious condition, was attended by an Aetna physician. Because Bear Valley Community Hospital has no acute cardiac care facilities and was therefore ill-equipped to handle Cynthia Ardary's cardiac condition, Cynthia's attending physician determined that Cynthia needed to be air-lifted to Loma Linda University Medical Center ("Loma Linda") for treatment. *Id.*, at 2a-3a.

The doctor called petitioner Arrowwest, the administrator of the Aetna plan, as required by Aetna. An Arrowwest employee refused the request to transfer Cynthia Ardary to Loma Linda and reiterated that refusal on at least two more inquiries — even after Cynthia subsequently went into cardiac arrest. *Id.*, at 3a.

At or about 2 p.m. on May 9, 1993, Cynthia died as a result of acute myocardial infarction — which was the direct result of Aetna's unreasonable refusal to transfer her to Loma Linda where she could have received proper cardiac care. *Id.*

B. Summary of Proceedings

The complaint in this action was filed on January 25, 1994 in the Superior Court of the State of California, County of San Bernadino. *Id.* The complaint does ***not*** seek payment of the benefits under Aetna's plan. *Id.*, at 3a-4a. Rather the primary cause of action is for the wrongful death of respondents' wife and mother resulting from petitioners' negligent refusal to provide authorization for the air ambulance needed to transfer Cynthia and for the petitioners' fraud in inducing Cynthia to enroll in the Aetna plan with the assurance that such transfers ***would*** be provided, if needed.

After removing the action to the United States District Court, Central District of California, Aetna moved to dismiss the action on the grounds that, in the words of the Ninth Circuit, "the Ardarys' ***exclusive*** remedy for their action 'relating to' the denial of Medicare benefits was the administrative appeals process provided by HCFA." (*Id.*, at 4a; emphasis added.) After the District Court granted petitioners' motion to dismiss, respondents appealed. *Id.*, at 4a.

The Ninth Circuit reversed, holding that the Medicare administrative review process does not, and was never intended to, preempt all state-law based causes of action and does not, and was never intended to, thereby immunize "Medicare providers and their representatives . . . in their individual capacity for tortious acts in the context of the denial of Medicare benefits. The removal of the right to sue the private Medicare provider for its torts would result in an inequitable and substantial dilution of the rights of patients." *Id.*, at 12a-13a.

SUMMARY OF REASONS FOR DENYING CERTIORARI

When the hyperbole is weeded out of the petitions and their misstatements, misdirection and inaccuracies are corrected, it is apparent that petitioners have failed to meet their burden of demonstrating that there is a "compelling reason" for this Court to review the Ninth Circuit's decision:

A. The factual circumstances in this action are unique and do not implicate the issues raised by petitioners.

In order to adequately address the issue petitioners want this Court to decide — *i.e.*, the scope of Medicare's administrative review provisions in the context of benefits provided by a health maintenance organization ("HMO") under 42 U.S.C. § 1395mm, this Court needs a "pure" factual situation presenting a clear and unequivocal denial of a benefit mandated by Medicare as well as consequential damages which cannot be corrected or remediated by subsequent payment of the denied benefits. There must be a factual matrix which is unencumbered by allegations of fraud or claims of entitlement to benefits over and above those required by Medicare.

This is not that case.

1. Petitioners misrepresent the nature of the issue presented.

For example, the "Questions Presented" by the petitioners misconstrue the real issues in this case. Aetna's "Question Presented" misrepresents respondents' state law action as "seeking both Medicare benefits determinations and consequential damages." Aetna Petition, at i. That is an outright falsehood. Respondents are ***not*** seeking a Medicare benefits determination — a Medicare benefits determination at this point

will not return Cynthia Ardary to the bosom of her family. She will still be dead.

Similarly, Arrowwest's "Question Presented" casts the issue as one "challenging Medicare benefits determinations." Arrowwest Petition, at i. Again, the benefits determination is not, *per se*, at issue: Petitioners' negligence and fraud are.

2. *Petitioners misrepresent the respondents' standing.*

Arrowwest also misrepresents the Medicare statute by claiming that the Medicare Act "requires ***any individual*** dissatisfied with a Medicare benefits determination to exhaust the administrative remedies prescribed by the Medicare Act." Arrowwest petition, at i.

But even as demonstrated in Arrowwest's own petition, the administrative review provisions applicable to Medicare determinations ***by an HMO*** permit the administrative process to be invoked ***only*** by "[a] ***member*** enrolled with an eligible organization under this section who is dissatisfied by reason of ***his*** failure to receive any health service to which ***he*** is entitled . . . ." 42 U.S.C. § 1395mm(c)(5)(B); emphasis added. Thus, under the express language provided by Congress, the ***only*** person with standing to seek administrative review of the denial of the airlift transport ***was Cynthia Ardary*** or, under 42 C.F.R. § 417.610, her estate. Neither Cynthia Ardary nor her estate is a party to this action — again, because the action ***does not seek recovery of*** **Medicare benefits.** It seeks damages for **wrongful death.**

Since respondents have no standing to invoke the administrative review provisions of Medicare, and thus no *power* to do so, common sense dictates that they also have no *duty* to do so.

3. Respondents have not "admitted" or "conceded" that their action is "predicated" on the denial of Medicare benefits such that the wrongful death claims are "inextricably intertwined" with the benefit determination.

Aetna's repeated assertions that respondents "admitted" or "conceded" that their action is "predicated" on the denial of Medicare benefits does not warrant the conclusion drawn by Aetna that the claims are therefore "inextricably intertwined" with the benefit determination such that the administrative remedies provisions control.

Aetna's analysis overlooks one simple fact that — irrespective of the larger issue — renders review by this Court wholly inappropriate: Aetna specifically and expressly represented to Cynthia Ardary that, should the need arise, she would be airlifted out of Big Bear to Loma Linda University Medical Center. The representation was not limited. The representation was not conditional. The representation was not tied in any way, shape or form to entitlement to the transfer as ***a Medicare benefit.***

The Medicare statutes relating to HMOs require the HMO to provide benefits at least to the level Medicare allows. ***But they also allow the HMO to provide*** **more** ***benefits.*** 42 U.S.C. § 1395mm(c)(2)(A)(ii). Thus, the denial of benefits in this case is not necessarily predicated on a denial of ***Medicare*** benefits — it is predicated on a denial of ***promised*** benefits. Because Aetna promised Cynthia that a transfer would be provided if she needed it — without conditioning that promise on compliance with Medicare — the claim is ***not*** "inextricably intertwined" with the Medicare statutes and the administrative review provisions are not implicated.

This unique factual context therefore does not warrant the expenditure of this Court's resources on a case which cannot accurately delineate the issue.

B. There is no conflict among the circuits.

Petitioners contend that review of the Ninth Circuit's decision is necessary because it conflicts with decisions from other circuits. That assertion of grounds for certiorari, however, directly conflicts with petitioners' other statement that "[t]he Ninth Circuit's decision is one of the first to deal with the preemption issue confronting a health maintenance organization which provides services to Medicare beneficiaries." Aetna petition, p. 20 and incorporated by reference into Arrowwest's Petition.

Indeed, petitioners are correct. There is not one other federal case which deals with Medicare's administrative review provisions ***as they apply to HMOs.*** There is only one state case which does so — *Solorzano v. Superior Court (Family Health Plan, Inc.),* 10 Cal. App. 4th 1135, 1148-1149, 13 Cal. Rptr. 2d 161, 169-170 (1991) — a California court of appeal decision in which this Court denied certiorari, 510 U.S. 814 (1993). Since this case is the only federal circuit court case addressing the issue, there obviously cannot be a conflict among the circuits.

C. This action does not raise important questions of public policy requiring this Court to protect Medicare HMOs in the same way ERISA fiduciaries are protected — because Congress did not intend to protect Medicare HMOs in the same way.

Petitioners' stated goal is to impose the same sweeping preemptive effect under the Medicare administrative review provisions for the protection of HMOs as exist under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.* Aetna Petition, at pp. 20-21. To that end, petitioners misrepresent that "both ERISA and the Medicare Act incorporate similar jurisdictional preemption provisions for

cases predicated on a benefit determination." Aetna Petition, at p. 21. The fundamental flaw in petitioners' argument, however, is the simple fact that ***Congress did not provide the same preemption language in both statutes.***

As this Court has repeatedly emphasized, ERISA's preemption language is extraordinarily broad, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549 (1987), and the provisions of ERISA "supersede ***any and all*** state laws insofar as they may now or hereafter **relate to** any employee benefit plan." (29 U.S.C. § 1144(a); emphasis added.) No such preemption language appears anywhere in the Medicare statutes. In fact, despite the amendment of certain portions of the Medicare statute to include specific preemption provisions, Congress has not included ***any*** specific preemption provision ***at all*** with respect to 42 U.S.C. § 1395mm — the provision applicable to health maintenance organizations providing benefits to Medicare beneficiaries. *Solorzano, supra,* 10 Cal. App. 4th at 1148-1149, 13 Cal. Rptr. 2d at 169-170 (1991). But that fact in no way impeded petitioners from inappropriately arguing as if it did.

D. The Ninth Circuit appropriately decided the issue and, even if it did not, an erroneous decision is not a proper basis for certiorari.

And last, but not least, the Ninth Circuit's decision and application of the relevant statutes and this Court's prior decisions was, in fact, correct. But even if the Ninth Circuit's analysis was erroneous, that is not a proper basis for a grant of certiorari given the absence of one of the other bases for justifying review. *Ticor Title Ins. Co. v. Brown*, __ U.S. __, __, 114 S. Ct. 1359, 1362 (1994) (certiorari will not be granted merely to correct an erroneous decision.) Since, as noted above, the other assertable grounds for justifying review do not exist in this case, the petitions should be denied.

REASONS FOR DENYING THE WRIT

I.

STANDARD FOR GRANTING WRIT OF CERTIORARI

The rules of this Court state that a petition for a writ of certiorari "will be granted only for compelling reasons." Sup. Ct. R. 10. In general, certiorari will be denied if the case involves circumstances or issues which are not likely to be repeated, *see Rice v. Sioux City Memorial Park Cemetery*, 349 U.S. 70, 74 (1955) (noting that the Court reviews issues that are "beyond the academic or the episodic"); 13 James W. Moore, ed., *Moore's Federal Practice*, ¶ 810.21 at SC 10-23 (2d ed. 1995) (stating that the Court will not be inclined to review "an issue that is unlikely to recur" or which "results from a unique factual situation"), or if "the asserted error consists of . . . the misapplication of a properly stated rule of law." Sup. Ct. R. 10. Moreover, certiorari will be granted "only 'in cases involving principles the settlement of which is of importance to the public, as distinguished from that of the parties, and in cases where there is a real and embarrassing conflict of opinion and authority' " between the courts of appeals. *NLRB v. Pittsburgh S.S. Co.*, 340 U.S. 498, 502 (1951) (quoting *Layne & Bowler Corp. v. Western Well Works*, 261 U.S. 387, 393 (1923)). This Court has also refrained from resolving conflicts that arise between panels within the same circuit, on the grounds that such conflicts should be resolved by the court of appeals internally. *See, e.g., Taylor v. United States*, 493 U.S. 906, 907 (1989); *Davis v. United States*, 417 U.S. 333, 340 (1974); *Wisniewski v. United States*, 353 U.S. 901, 902 (1957).

II.

BECAUSE THE FACTS IN THIS CASE INCLUDE ALLEGATIONS OF FRAUD, THEREBY CREATING A POTENTIAL THAT THE BENEFITS SOUGHT WERE IN EXCESS OF THOSE MANDATED BY MEDICARE, REVIEW IS NOT WARRANTED.

The predicate for petitioners' request for review of the Ninth Circuit's decision in this case is the assertion that the Medicare administrative review provisions are the exclusive means of determining any right or claim related to a decision by a Medicare-contracted health maintenance organization. But this case does not present that question unencumbered by other circumstances. As the Ninth Circuit noted in framing the issue to be decided by it, the question is whether the exclusive administrative review provisions of the Medicare Act "apply to preclude the heirs of a deceased Medicare beneficiary from bringing state law claims for wrongful death against a private Medicare provider when those claims do not seek recovery of Medicare benefits but instead seek compensatory and punitive damages on the grounds that the provider both improperly denied emergency medical services ***and misrepresented its managed care plan to the beneficiary?***" App., at 7a-8a; emphasis added.

As noted above, the Medicare Act mandates the minimum level of benefits HMOs must provide to their members. But 42 U.S.C. § 1395mm(c)(2)(A)(ii) allows the HMO to provide ***additional*** benefits over and above the mandated minimum. And 42 C.F.R. §§ 417.604(b)(3) and (c) specify that such supplemental benefits ***are not subject to the appeal procedures*** which Aetna is seeking to impose. *See also,* 42 C.F.R. § 417.606(b)(2) (denials regarding supplemental benefits are not "organizational determinations" for purposes of administrative review requirements [42 C.F.R. § 417.604 (a)(1)(ii)]).

Thus, the denial of the request for authorization for the airlift is ***not*** subject to the Medicare administrative review provisions if it falls within the ambit of a "supplemental" benefit. Inherent to the fraud allegations of the complaint is the conclusion that the airlift benefits were promised to Cynthia irrespective of and apart from any coverage Medicare would provide. By making those representations, Aetna personally assumed a duty to provide the airlift benefits — and thereby took the benefits outside the Medicare Act requirements.

Petitioners provided to this Court neither facts nor law demonstrating that the airlift was a Medicare-defined benefit in the first instance. Nor have respondents "conceded" or "admitted" that it was. The portion of the respondents' brief quoted by the Ninth Circuit — and ***misquoted*** by petitioners — does not "admit" that the entire action is "predicated" on the denial of ***Medicare*** benefits. Rather, the statement relied on by the Ninth Circuit only states that " 'the wrongful death action is predicated on the allegation that ***the*** benefits were, in fact, owed and were, in fact, wrongfully denied.' " (App., at 4a, n. 4; emphasis added.) Since petitioners have not shown that "***the*** benefits" owed and wrongfully denied were ***Medicare*** benefits, rather than supplemental or additional benefits owed under the fraud cause of action — and have concomitantly failed to show that the Medicare administrative review process was even triggered — petitioners have also failed to demonstrate a basis for review by this Court.

III.

PETITIONERS HAVE ADMITTED THAT THERE IS NO CONFLICT AMONG THE CIRCUITS ON THE ISSUE PRESENTED.

To support their claim that grounds for this Court's review exist, petitioners argue vociferously that the Ninth Circuit's rationale in this case creates a conflict among the circuits because, petitioners assert, it misapplies the "arising under" standard for determining whether Medicare review provisions apply based on this Court's past decisions and the rationale in the Seventh Circuit's decision in *Bodimetric Health Services, Inc. v. Aetna Life & Casualty*, 903 F.2d 480 (7th Cir. 1990), *cert. denied*, 498 U.S. 1012 (1990). Aetna Petition, p. 13. But petitioners are also forced to concede later in their petitions that ***no other case has decided the issue presented here:***

> The Ninth Circuit's decision is one of the first to deal with the preemption issue confronting a health maintenance organization which provides services to Medicare beneficiaries.

Aetna Petition, at p. 20.

Similarly, the Ninth Circuit itself noted the dearth of cases dealing with the interplay between the Medicare review statutes and 42 U.S.C. § 1395mm, the section of the Medicare Act dealing with HMOs. App., at 8a, n. 8. In fact, an examination of the annotations to § 1395mm reveals ***no*** other federal case regarding this issue and discloses only one state case — *Solorzano*. And although the *Solorzano* court conducted an extensive and thorough analysis of the preemption issue presented by the Medicare Act's administrative remedy

provisions, it did so in the context of allegations of fraudulent marketing practices, not wrongful claim determinations.

Despite the petitioners' assertion that the *Bodimetric* case presents a "direct and apparent" conflict among the circuits, Aetna Petition, at p. 13, the unvarnished truth is that it does not. That is because *Bodimetric* did not involve an HMO and *Bodimetric* was not decided under § 1395mm.

In *Bodimetric,* Aetna played a role entirely different from that at issue in this case. In *Bodimetric,* Aetna was a Medicare fiscal intermediary as set forth in 42 U.S.C. § 1395h which, on behalf of the Medicare administration, determined benefits to be paid to certain providers. Thus, its role in that case was as a representative of the federal government in the determination of what benefits would be approved for payment by Medicare. In this case, Aetna was an HMO regulated under 42 U.S.C. § 1395mm and was itself the medical care provider.

Also in *Bodimetric,* the medical care provider plaintiff was, in fact, seeking recovery of Medicare benefits which were alleged to have been wrongfully withheld. As repeatedly noted by the Ninth Circuit in its decision in this case, respondents do not seek reimbursement for Medicare-covered expenses for the simple reason that no Medicare covered expenditures were made.

Since *Bodimetric* did not deal with an ***HMO's*** denial of benefits, since *Bodimetric* did not arise under § 1395mm and since *Bodimetric* did not involve a claim seeking anything other than Medicare benefits, there is, in point of fact, no conflict — direct or otherwise — between the circuits because the Ninth Circuit is the only federal court to have addressed the question presented.

IV.

SINCE THE MEDICARE ADMINISTRATIVE REVIEW PROVISIONS ARE IN NO WAY ANALOGOUS TO THOSE OF ERISA, AND SINCE PETITIONERS CANNOT DEMONSTRATE THAT MEDICARE HMOs ARE ENTITLED TO THE SAME BROAD PROTECTIONS AS ARE ERISA FIDUCIARIES, PETITIONERS' CLAIM OF IMPORTANCE OF THE ISSUE PRESENTED RINGS HOLLOW.

Petitioners ring down a forecast of doom and destruction for Medicare HMOs if the Ninth Circuit's decision is not reviewed and reversed and petitioners thereby try to create an issue of importance warranting this Court's intervention. But the reports of the death of the Medicare HMO industry are greatly exaggerated. And even if all of Aetna's fears came to pass, that is a consequence not of the Ninth Circuit's decision but of Congress's drafting of the Medicare statutes as they relate to HMOs.

Petitioners try desperately to analogize the Medicare review provisions to those of ERISA. But that analogy is not merely false, it is not even credible. For example, compare the preemption language of ERISA, the Federal Employee Hospital Benefits ("FEHBA"), 5 U.S.C. § 8902(m)(1), and Medicare:

ERISA	FEHBA	MEDICARE
ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).	FEHBA "shall supersede and preempt any State or local law . . . to the extent inconsistent with such contractual provisions." 5 U.S.C. § 8902 (m)(1).	Under Medicare, "[a]ny individual, after any final decision of the Commissioner of Social Security . . . may obtain review of such decision by a civil action. . . . The court shall have the power to enter . . . a judgment affirming, modifying, or reversing the decision . . ." 42 U.S.C. § 405(g).

To compare the complete preemption of "any and all State" laws under ERISA and FEHBA to the administrative review provisions of Medicare is overreaching of the worst sort. Nowhere in the Social Security Act or in the Medicare Act, as it applies to Medicare HMOs under § 1395mm, did Congress even implicitly attempt to preclude tort actions based on a Medicare HMO's wrongful conduct. As quoted by the Ninth Circuit from this Court's decision in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 680, 106 S. Ct. 2133, 2141 (1986):

> Indeed, the "legislative history of both the statute establishing the Medicare program and the 1972 amendments thereto provides specific evidence of Congress' intent to foreclose review only of 'amount determinations' — i.e., those 'quite minor

> matters,' 118 Cong. Rec. 33992 (1972) (remarks of Sen. Bennett), remitted finally and exclusively to adjudication by private insurance carriers in a 'fair hearing.' "

App., at p. 12a.

The upshot of that was cogently articulated by the Ninth Circuit in its decision in this case:

> We find nothing in the legislative history [of the Medicare Act] to suggest that the Act was designed to abolish all state remedies which might exist against a private Medicare provider for torts committed during its administration of Medicare benefits pursuant to a contract with HCFA.

App., at p. 12a.

As has been widely recognized, ERISA's preemption provision has erected an impenetrable wall of immunity around insurers and HMOs in dealing with employment-related benefits decisions which has caused, and continues to cause, much chagrin in Congress. But even if Congress did intend the immunity protections derived from ERISA's preemption language in the employment context, there is no justification for expanding that immunity into areas where no such intent was even hinted at, let alone expressed. Congress obviously knows how to enact a broad preemption provision when it intends to — and did so in ERISA and FEHBA. But there is nothing in the language of the Medicare statutes, or in the congressional intent or the legislative history underlying them, that justifies foreclosure of the respondents' tort claims ***even if the action is one "arising under" the Medicare statutes.***

Additionally, one of the congressional purposes in enacting ERISA in the first instance was to protect employee pension and benefit funds from mismanagement and loss. In order to assure the ready availability of funds for the benefit of the employees, Congress used such broad preemptive language so as to provide a consistent and orderly administrative structure for ERISA fiduciaries. ***But a Medicare HMO is not an ERISA-type fiduciary. A Medicare HMO has no employee fund to administer. A Medicare HMO has no need of a consistent and orderly administrative structure.***

In contrast to the situation in ERISA — where one of the primary goals was a consistent regulatory framework in order to preserve the availability of plan funds — the Medicare Act's sole purpose is to assure that America's aged and disabled are provided with a minimum level of medical care. *Massachusetts Medical Soc. v. Dukakis,* 815 F.2d 790, 794 (1st Cir. 1987) (the basic purpose of the Medicare Act is "to insure adequate medical care for the elderly").

Obviously, imposing tort liability on an HMO which ***wrongfully*** refuses to authorize treatment or care to which the member is entitled under Medicare and/or the member's contract with the HMO will not discourage or hamper the HMO's vigilance in assuring that appropriate care is provided as required under Medicare. On the contrary, potential liability for such damages will encourage and enhance the HMO's appropriate and proper provision of promised benefits — and will assure that Congress' intent is fulfilled.

Indeed, petitioners' citation to statistics demonstrating the increasing numbers of senior Americans enrolling in Medicare HMO plans emphasizes the importance of ***not*** permitting Medicare HMOs to operate in a zone of absolute immunity. It is certainly understandable why Aetna and the other HMOs would

like to have the same immunity shield in the Medicare context as they do in the ERISA context. But since neither the language nor intent of ERISA is analogous to the language and intent of Medicare, petitioners' effort to create an "issue of importance" in order to entice this Court's interest by seeking to expand Medicare's administrative review provisions into a broad and sweeping preemption provision like that in ERISA is deceptive and dishonest.

V.

EVEN IF THE FACTUAL AND LEGAL CONTEXT WERE DIFFERENT, CERTIORARI WOULD BE INAPPROPRIATE BECAUSE THE NINTH CIRCUIT'S DECISION WAS CORRECT.

Over and above all the other reasons that certiorari is inappropriate in this case is the simple fact that the Ninth Circuit was right. Even assuming there were no fraud allegation, even assuming the airlift transport was covered under Medicare and not under any supplementary coverage, even assuming the damages claimed were "predicated" on a wrongful denial of Medicare benefits, the decision was right.

A. The foundational question of whether the "arising under" provision of 42 U.S.C. § 405(h) even applies to Aetna in its role as an HMO under § 1395mm has never been addressed by petitioners.

Petitioners' argument is grounded on the application of 42 U.S.C. § 405(h) which provides, in pertinent part, that "[n]o action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any ***claim arising under*** this subchapter." (Emphasis added.) The application of the "arising

under" language is the jumping-off point at which petitioners and the Ninth Circuit's respective analyses diverge.

But there is a foundational issue which was never raised or addressed by either petitioners or the Ninth Circuit — although it was argued by respondents. One distinction between this case and every other case referenced by both the Ninth Circuit and the petitioners is that all the cited cases were brought against the Secretary or an officer or employee of the government. But there is no case holding that an HMO is transmuted into "an officer or employee" of the government when it contracts with HCFA to become a provider of medical care services for Medicare enrollees.

And that situation is expressly distinct even from *Bodimetric,* the case so heavily relied on by Aetna. In *Bodimetric,* Aetna was a Medicare fiscal intermediary which, on behalf of the Medicare administration, determined benefits which were to be paid to certain providers. The plaintiff in *Bodimetric* was a home health care agency which provided home health care services to Medicare patients. Under Medicare, the Secretary of Labor was charged with the duty to determine and pay the claims by those providers. However, Medicare also allowed the Secretary to assign those obligations to entities known as "fiscal intermediaries."

> A fiscal intermediary is an entity that has contracted with the Secretary to determine for the Secretary whether services provided . . . are covered under the Medicare Act and the amount due the provider of services.

Homewood Professional Care Center, Ltd. v. Heckler, 764 F.2d 1242, 1244, n. 2 (7th Cir. 1985).

As determined in *Bodimetric*, the fiscal intermediary is an "officer or employee" of the Secretary and is protected from legal actions to the same extent as the Secretary under § 405(h). But there is no basis for concluding that an HMO under § 1395mm is the equivalent of a fiscal intermediary acting on behalf of the government under § 1395h. Rather the HMO in a case under § 1395mm is actually a ***medical provider*** — just like the ***plaintiff*** in *Bodimetric*. The only difference is that a Medicare HMO is paid a flat monthly rate rather than on a fee-for-service basis. *See Solorzano, supra,* 10 Cal. App. 4th at 1140, 13 Cal. Rptr. 2d 163-164. To extend § 405(h) to a Medicare HMO would insulate the HMO — and every other Medicare provider — from negligence liability even for medical malpractice — an inconceivable result.

B. The claims asserted in this case cannot logically or rationally "arise under" Medicare because respondents have no standing to invoke the administrative review process and both the standing and the substantive basis for the damages claimed arise solely under state law.

Even assuming the foundational determination that a Medicare HMO is entitled to invoke 42 U.S.C. § 405(h), the Ninth Circuit's analysis of whether the respondents' claims "arise under" that section was correct.

This Court's cases — cited by both petitioners and the Ninth Circuit — establish that for § 405(h) to apply, the claim must "arise under" the Medicare statutes in the first instance. In *Heckler v. Ringer,* 466 U.S. 602, 615, 104 S. Ct. 2013, 2021-2022, 80 L. Ed. 2d 622 (1984), this Court concluded that for an action to "arise under" Medicare the action must include "claims in which 'both the standing and the substantive basis for the presentation' of the claims" is the Medicare Act. None of those elements are present here.

First, the respondents have no standing to seek review under the Act. The ***specific*** administrative review provisions under § 1395mm — the part of the Act applicable to HMOs — allow the administrative process to be invoked ***only*** by "[a] ***member*** enrolled with an eligible organization under this section who is dissatisfied by reason of ***his*** failure to receive any health service to which ***he*** is entitled. . . ." 42 U.S.C. § 1395mm(c)(5)(B); emphasis added. Thus, under the express language provided by Congress, the ***only*** person with standing to seek administrative review of the denial of the airlift transport ***was Cynthia Ardary*** or, under 42 C.F.R. § 417.610, her estate. Neither Cynthia Ardary nor her estate is a party to this action — again, because the action ***does not seek recovery of Medicare benefits.*** It seeks damages for ***wrongful death***. Since the respondents have no standing under the Act to even invoke the administrative review provisions, their claims cannot logically "arise under" the Act.

Second, the fact that respondents are seeking wrongful death damages is what provides the sole basis for the standing which ***does*** exist. As repeatedly emphasized by the Ninth Circuit, the respondents are not seeking Medicare ***benefits*** — again because retroactive approval of the airlift will do nothing to restore Cynthia Ardary to life and cannot compensate for the actual damages caused by her death. It would indeed be anomalous to hold that a wrongful death claim "arises under" the Medicare Act when, in fact, a determination that the Medicare benefits should have been paid will do nothing to compensate the parties for their losses.

In fact, respondents' action is predicated on their ***independent legal right*** to recover damages from one whose negligence causes the death of a spouse or parent. That legal right is not derivative of Cynthia Ardary's rights under the Aetna plan and does not "relate to" the benefits owed in the sense that term is used in the preemption context. That is because

California's wrongful death statute creates a *new cause of action* based on the heirs' own ***independent*** pecuniary injury suffered as the result of the loss of a relative. California Code of Civil Procedure, § 377.60; Witkin, *Cal. Summary*, 9th Ed., Torts, Vol. 6, § 1197. Petitioners therefore owed their own primary, independent duty of care to the ***heirs*** of Cynthia Ardary, separate and apart from their duty under the Senior Care plan to actually authorize payment of the benefits.

Thus, the respondents' standing is not dependent on the Medicare Act and, in turn, the substantive basis for their right of action arises under state law — *i.e.*, under California's wrongful death statute. That being the case, their claim does not "arise under" the Act. Since it does not "arise under" the Act, it is not subject to the administrative review provisions of the Act.

C. Nor are the claims "inextricably intertwined" with the Medicare determination.

Petitioners erroneously argue that, irrespective of the fact that no Medicare benefits are claimed, the wrongful death damages are "inextricably intertwined" with the Medicare determination and therefore mandate preemption. Petitioners do not explain, however, exactly how the Medicare administrative review procedures will provide standing to respondents to assert their claims. Nor do they explain how the Secretary, at the ultimate pinnacle of the review process, can award benefits which were never used and which can no longer be used. Nor do they explain how the Secretary can compensate Cynthia's husband and children for the loss of her care, comfort and society — the damages recoverable for her wrongful death.

The "inextricably intertwined" language used by this Court and the "arising under" provision used by Congress must be

applied rationally. If the administrative review process cannot compensate for the injuries done by a Medicare HMO either in its failure to provide needed care or in its negligent provision of needed care, the claim at issue is not "inextricably intertwined" with the Medicare-based decision because reversal of the Medicare-based decision cannot correct or compensate for the consequential injuries.

All of the cases cited by and relied on by petitioners related "at bottom" to an intent to recover the actual Medicare payments themselves and ***not one*** dealt with a claim seeking solely consequential damages from the failure to provide Medicare services needed by an enrollee:

- *Weinberger v. Salfi*, 422 U.S. 749, 760-761 (1975) involved a constitutional challenge to the portion of the Social Security Act limiting widow and orphan benefits. The widow in *Salfi* was not bringing the challenge out of the goodness of her heart. She was bringing the challenge in order to qualify for Social Security benefits. Moreover, there could be no recovery for consequential damages resulting from the denial of those benefits because any denial in compliance with the statutory mandate could not, by definition, be tortious.

- In *Heckler v. Ringer*, 466 U.S. 602, 605 (1984) Medicare beneficiaries sought declaratory and injunctive relief regarding denials of coverage for a particular surgical procedure. Though cast as a claim for equitable relief, the equitable relief sought would have had the practical effect of requiring Medicare to pay the benefits claimed for the procedure. Again, no consequential damages were claimed — only the benefits.

The court of appeals decisions from the other circuits cited by petitioners are all to the same effect:

- *Bodimetric* was an action brought by medical providers seeking payment for care provided to Medicare enrollees;

- *Manakee Professional Medical Transfer Service, Inc. v. Shalala*, 71 F.3d 574 (6th Cir. 1995) was a case brought by a medical provider (ambulance transportation) seeking retroactive Medicare payments;

- *Hatcher v. Heckler*, 772 F.2d 427 (8th Cir. 1985) involved an action seeking damages under Part B of the Medicare Act by claimants;

- *American Federation of Home Health Agencies, Inc. v. Heckler*, 754 F.2d 896 (11th Cir. 1984) was an action by Medicare providers challenging reimbursements provisions;

Petitioners' citation to two older Ninth Circuit cases as being in conflict with the decision in this case is similarly inapposite. In *Marin v. HEW, Health Care Financing*, 769 F.2d 590 (9th Cir. 1985), *cert. denied*, 474 U.S. 1061 (1986), the Ninth Circuit held that a provider's claim for financial damages resulting from the delayed payment of reimbursement owed to him was subsumed under 42 U.S.C. § 1395oo which sets forth a different review procedure for Medicare providers and which expressly provides interest on wrongfully delayed payments. Since no part of the Medicare statutes or the administrative review sections incorporated into them permit recovery by these respondents — who have no standing under the statutes — or permit recovery of the damages caused by petitioners' negligence, *Marin* is inapplicable.

Petitioners also rely on *Hooker v. United States Dept. of Health & Human Services,* 858 F.2d 525 (9th Cir. 1988), a wrongful death action brought against the Secretary, the Department and their employees for negligently terminating the Social Security benefits of the decedent, thus triggering his suicide. The problem with the application of *Hooker* to this case is the simple fact that the plaintiffs were suing the very parties § 405(h) forbids actions against: The Secretary, the government and their employees. None of those parties are defendants in this action.

Moreover, the *Hooker* court failed to distinguish the holding in *Jimenez-Nieves v. United States,* 682 F.2d 1 (1st Cir. 1982). In that case, the son of a Medicare recipient sued for consequential damages resulting from Social Security's negligent action in dishonoring checks issued to the recipient and cashed by the son for payment of the recipient's bills. The Administration dishonored the checks due to a keypunch error indicating that the recipient had died when, in fact, she had not. The court of appeals held that the action did not "arise under" § 405(h) as delineated in *Salfi* and noted:

> An action for damages based on a tort committed in the course of administering the Social Security Act does not arise "under" a "subchapter" that provides for the payment of social security benefits any more than a tort claim based on a negligently driven postal truck arises under the postal acts. . . .
>
> More importantly, however, to accept the Government's argument would imply that tort claims against the Government in general arise not only under the Federal Tort Claims Act and state law, but also under whatever statute the defendant agency happens to be

> administering. . . . Thus, the Government's argument, if accepted, would replace a reasonably uniform and clear system for handling tort suits against the government (embodied in the Tort Claims Act) with a hodgepodge of procedural requirements, drawn from a host of different statutes not necessarily drafted with tort suits in mind. In this case, for example, the "administrative hearing" procedures of § 405(g) are well suited to the decision of benefit claims. But they are anomalous if applied to tort claims. . . . We are aware of no reason why so totally different a system for resolving tort claims against the government should apply to claims that happen to grow out of administration of the Social Security Act. The Government offers us no evidence that such was the intent of Congress, here or elsewhere, nor does it explain how, or why, that result would be desirable. Thus, we find its "jurisdictional" argument without merit.

Jimenez-Nieves, 682 F.2d at 3.

That rationale applies with even greater force here since petitioners are neither the "Government" nor representatives of the "Government." Rather, they are Medicare ***providers*** whose negligent conduct is in no way even remotely intended to be protected by § 405(h).

And, unlike all the cases relied on by petitioners, this case does not seek reimbursement for payment of medical care which should have been provided by Medicare, nor does it seek direct or indirect payment of any Medicare benefits. Because this is

not an action which in any way, shape or form seeks the Medicare benefits themselves, the Ninth Circuit's decision was not only correct under this Court's rationale in the "arising under" decisions, it is the only logical one in the context of the issues here.

CONCLUSION

The petitions presented to this Court rely on misstatements of fact, misapplication of law and misdirection of analysis in order to achieve the goal of obtaining review of a correct decision. The petitioners' rhetoric and obduracy are understandable: They naturally long to escape from the consequences of their unreasonable and bad faith refusal to provide the airlift transfer they owed to Cynthia Ardary under their contract with her. But a defendant's desire to escape the consequences of its own wrongful conduct has never been a sufficient basis for invoking this Court's scrutiny and this case presents nothing — either factually or legally — warranting a change in that long-standing policy.

The petition for certiorari should be denied.

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v.

William Ardary, *et al.*,

Respondents.

On Petition for Writ of Certiorari to the
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for the Ninth Circuit

PETITIONERS' REPLY TO OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

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INTRODUCTION

Respondents marked avoidance of the issues actually raised in the Petition punctuates the reasons why the writ should be granted. When Respondents' mischaracterization of the case is corrected, their effort is fairly seen as an end run around what was intended by Congress, and held previously by this Court, to be an exclusively-federal dispute resolution scheme. Clearly, the Ninth Circuit has misapplied this Court's decisions in *Weinberger v. Salfi*, 422 U.S. 749 (1975), *Heckler v. Ringer*, 466 U.S. 602 (1984) and *Schweiker v. Chilicky*, 487 U.S. 412 (1988), and clearly the Ninth Circuit's opinion has caused a split among the circuits on the points raised herein.

The Ninth Circuit's decision improperly redirected federal caselaw by permitting Respondents' wrongful death action. In light of the potential impact that that decision could have on cases that ultimately will be brought among both present Medicare enrollees and the 80,000 new enrollees per month who enter Medicare-covered health maintenance organizations ("HMOs") across the country, this Court's review of that decision is vitally necessary.

REASONS FOR GRANTING THE WRIT

I. IN FABRICATING A NEW REMEDY FOR RESPONDENTS, THE NINTH CIRCUIT FLATLY MISAPPLIED THIS COURT'S DECISIONS IN *WEINBERGER V. SALFI*, *HECKLER V. RINGER* AND *SCHWEIKER V. CHILICKY*.

The Ninth Circuit flatly misapplied this Court's standard in *Salfi* and *Ringer* for determining when a claim "arises under" the Medicare Act. By permitting Respondents' wrongful death action, the Ninth Circuit provided Respondents with a remedy outside the congressionally-mandated exclusive remedial scheme, in direct contradiction of *Chilicky*. That scheme cannot be avoided merely because Respondents seek a remedy for which the Medicare Act makes no provision.

A. In devising a limited review process, Congress fashioned the remedies it deems necessary and exclusive to effectuate the uniform Medicare benefits process.

Remedies at law or equity are defined only by reference to principles established in caselaw or statute. With reference to the instant case, § 405(h) sets forth the exclusive avenue of

redress delineated by this Court's decision in *Salfi*, *Ringer*, and *Chilicky*. The Ninth Circuit's decision misapplied these standards and bypassed that congressionally-mandated remedial scheme.

In *Salfi* and *Ringer*, this Court assigned a broad application of the phrase "arising under" the Medicare Act to enforce faithful adherence to the jurisdictional preemption provision of 42 U.S.C. § 405(h). Thus, in *Salfi* this Court held that § 405(h) "extends to any 'action' seeking 'to recover on any (Social Security) claim' -- irrespective of whether resort to judicial processes is necessitated by discretionary decision of the Secretary." *Salfi*, 422 U.S. at 762. *See also Ringer*, 466 U.S. at 615 ("arising under" language is to be construed "quite broadly"). Accordingly, a claim predicated on a Medicare benefits determination is subject to the jurisdictional preemption provision of § 405(h), even if no statutory remedy is available.

Indeed, this Court has made abundantly clear that "[w]hen the design of a Government program suggests that Congress has provided what it considers adequate remedial mechanisms for . . . violations that may occur in the course of its administration, we have not created additional . . . remedies." *Chilicky*, 487 U.S. at 423. The Ninth Circuit simply ignored this basic principle and, contrary to congressional pronouncement, gave Respondents access to a forum -- a state court jury trial for consequential damages -- which Congress has foreclosed. This Court's intervention is thus necessary to redirect federal caselaw back to the course it set in *Salfi*, *Ringer*, and *Chilicky*.

B. The Ninth Circuit misapplied *Salfi*, *Ringer*, and *Chilicky* because it ignored that Respondents' claim is predicated on the finding of a "wrongful" administration of Medicare benefits.

The Ninth Circuit's misapplication of this Court's standards becomes clear upon close scrutiny of Respondents' supposed wrongful death claim. Under California law, the success of that claim would require an adjudication that Petitioners wrongfully or negligently denied the Medicare benefit at issue in this case. *See* California Code of Civil Procedure, § 377.60 (1996) (a cause for wrongful death lies if death was "caused by the wrongful act or neglect of another").

Whether Petitioners acted "wrongfully" or "negligently" in the administration of Medicare benefits is a determination framed solely by reference to the Medicare Act. Accordingly, notwithstanding Respondents' insistence that they brought a tort claim, not a Medicare benefits claim, any litigation on the facts presented necessarily depends upon a determination that "arises under" the Medicare Act, as described in *Salfi*. And *Salfi's* deference to the jurisdictional bar of § 405(h) is precisely what Congress described in creating an administrative remedy by which to contest the administration of Medicare benefits. *See Hooker v. United States Department of Health and Human Services*, 858 F.2d 525, 529-30 (9th Cir. 1988) (alleged wrongful termination of decedent's social security benefits which allegedly caused his suicide was barred by exclusivity of remedy provision in social security laws).

Again, merely because Respondents seek a particular remedy for which the Medicare Act makes no provision, they are not exempted from the operation of the Act's jurisdictional

bar. The Ninth Circuit might have followed its heart in cobbling a different remedy for Respondents than that which Congress intended, but it did not follow the law. This Court should grant the writ to correct this error which, left unattended to, will create a precedent shunting thousands of Medicare-HMO cases from the exclusive system intended by Congress to the whims of tort juries and awards of consequential and punitive damages in the State courts.

II. THE NINTH CIRCUIT'S DECISION CREATES A SPLIT IN THE CIRCUITS WHICH SHOULD BE RESOLVED BY THIS COURT.

Contrary to Respondents' caviling, the Ninth Circuit's decision herein has created a split among the circuits as to whether state law actions seeking both Medicare benefits determinations and consequential damages are preempted by federal law. Indeed, the Ninth Circuit, in this case, disagreed openly with the Seventh Circuit's decision in *Bodimetric Health Services, Inc. v. Aetna Life & Casualty*, 903 F.2d 480 (1990), and the division created thereby is unlikely to be resolved by future adjudication in those courts.

The Ninth Circuit could hardly have been more explicit in rejecting the Seventh Circuit's interpretation of § 405(h), when it stated that the Seventh Circuit's reasoning "certainly do[es] not suggest, at least to this court, that [the Seventh Circuit's view of the law] is the standard for making the critical judgment call about what 'arises under' the [Medicare] Act." *Ardary v. Aetna Health Plans of California, Inc.*, 98 F.3d 496, 501 (1996). In other words, had this case been brought in the Seventh Circuit, it would have been dismissed for lack of jurisdiction; because it was brought in the Ninth, it lives on.

Respondents contend that there is no split because they claim that no other federal case has addressed § 405(h) *as it applies to HMOs*.[1] Respondents' Brief in Opposition, at 7. That is a distinction without any material difference in the law. It is wholly irrelevant whether a Medicare benefits determination is made by an HMO or by a Medicare intermediary. In either case, the § 405(h) jurisdictional bar applies to *all claims* predicated on such a benefits determination. *Compare* 42 U.S.C. § 1395mm(c)(5)(B) (a dissatisfied HMO enrollee is entitled to judicial review *of Secretary's final decision* pursuant to § 405) with, *e.g.*, 42 C.F.R. § 405.710(b) (fiscal intermediary determinations subject to jurisdictional bar). Respondents' arguments to the contrary are utterly without merit. There is an inter-circuit split which this Court should resolve.

III. LEFT UNCHECKED, THE UNCERTAINTY CREATED BY THE NINTH CIRCUIT'S DECISION WILL HAVE FAR-REACHING IMPLICATIONS.

The Ninth Circuit's decision, if allowed to stand in light of its conflict with *Salfi*, *Ringer*, *Chilicky*, and *Bodimetric*, would permit Medicare plaintiffs remedies not contemplated by Congress. To proceed directly to state court, a shrewd Medicare plaintiff need only style his complaint in such a way as to avoid discussion of the payment of Medicare benefits. By

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[1] Respondents' contention that no other federal court has addressed the jurisdictional bar in the HMO context is patently false. In *Grijalva v. Shalala*, 946 F. Supp. 747, 750-55 (D. Ariz. 1996), the court held that an HMO is the Secretary's agent for purposes of administering Medicare benefits and is thus subject to the jurisdictional bar of § 405(h).

opening this large loophole, the Ninth Circuit has created an exception to § 405(h) that would allow artful pleading to void the rule of law.

The uniform resolution of the exploding Medicare population's claims is essential to the proper functioning of the federal Medicare program and Medicare's continued expansion into managed health care programs. Medicare HMOs are currently enrolling over 80,000 new members per month. *Washington Health Week*, No. 5, Vol. 5, Atlantic Information Services, Inc., Feb. 3, 1997. The Ninth Circuit's holding could impose significant additional costs (and, therefore, diminished benefits) if benefit decisions by Medicare HMOs are subject to second guessing by state court juries for consequential and punitive damages. For this important reason alone, this Court's intervention is necessary to ensure faithful application of Congress' mandate in § 405(h).

IV. MEDICALLY APPROPRIATE AIR AMBULANCE SERVICES ARE COVERED BY MEDICARE AND CLAIMS THEREFOR "ARISE UNDER" THE MEDICARE ACT.

Respondents' principal argument is that "[b]ecause the facts in this case [create] a potential that the benefits sought were in excess of those mandated by Medicare, review [by this Court] is not warranted." *Respondents' Brief in Opposition*, at 10. This new argument, never addressed below -- that air transportation benefits are supplemental Medicare benefits not subject to the jurisdictional bar -- is not supported by the applicable regulations. Those regulations quite clearly provide that medically-appropriate air ambulance services *are* covered services under Medicare.

Under the regulations, enrollment eligibility into a Medicare HMO plan, such as Aetna's Senior Choice plan, is limited to individuals entitled to receive benefits at least under Part B of the Medicare Act. 42 C.F.R. § 417.420(a). Part B benefits are the sole source of payment for medically-appropriate ambulance services, including air ambulance services. 42 C.F.R. § 410.40(b). In turn, "[m]edically appropriate air ambulance transportation is a covered service regardless of the State or region in which it is rendered" to an eligible beneficiary. *Medicare Carriers Manual, Part 3 (HCFA-Pub. 14-3)*, § 2120.4; *Medicare Intermediary Manual, Part 3 (HCFA-Pub. 13-3)*, § 3114(C)(11).

Respondents, simply are hoist by their own petard. Because "[m]edically appropriate air ambulance transportation is a covered service," the major premise for Respondents argument is exploded and, even by their own terms, one must conclude that the denial of a request for air ambulance transportation is subject to the jurisdictional bar of § 405(h). *See Klementowski v. Secretary, Department of Health and Human Services*, 801 F. Supp. 1022 (W.D.N.Y. 1992) (detailing the administrative procedures the claimant exhausted before seeking a judicial determination that air ambulance services are covered by Medicare).

CONCLUSION

For the reasons stated, the petition for writ of *certiorari* should be granted.

Respectfully submitted,

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Supreme Court, U.S.
FILED
MAY 22 1997

Nos. 96-1377 & 96-1526

In The

Supreme Court of the United States

October Term, 1996

AETNA HEALTH PLANS OF CALIFORNIA, INC., *et al.*,

Petitioners,

-and-

INLAND HEALTHCARE GROUP/ARROWWEST PHYSICIAN ASSOCIATION,

Petitioner,

vs.

WILLIAM ARDARY, *et al.*,

Respondents.

On Petitions for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

REPLY BRIEF FOR PETITIONER ARROWWEST PHYSICIAN ASSOCIATION

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INTRODUCTION

Respondents continue to mischaracterize the nature of their claims in order to escape the exclusive Medicare jurisdictional scheme. Their opposition to *certiorari* also reveals a fundamental misunderstanding of the law governing Medicare's regulatory mechanism. As a result, Respondents misstate the significant consequences of the Ninth Circuit's erroneous decision in this case.

Medicare law must apply because the central premise of Respondents' case is that benefits due under a Medicare HMO plan were wrongfully denied. It is irrelevant that a Medicare program agent made the benefits determination, that the plan also offered some supplemental benefits, that the beneficiary is now deceased, and/or that a retrospective administrative determination could not fully compensate them for their loss. All of those contingencies are contemplated by the Medicare statutes and regulations, which indicate clearly that the Medicare administrative process applies in such cases. Similarly, the prior case law in this area establishes unequivocally that Respondents' insistence that they are suing to recover *damages* caused by the denial of benefits is a meaningless *non sequitur*, because this plainly is a *Medicare benefits* case.

Moreover, the negative reach of the Ninth Circuit's erroneous decision extends much further than Respondents suggest. Courts already are interpreting the decision as holding that any lawsuit for consequential damages resulting from an alleged wrongful denial of benefits by a Medicare HMO may be pursued in state court without prior exhaustion of the Medicare administrative process created for adjudicating the propriety of such denials.[1] Given the

1. For example, in *Minka v. Pacificare of California, et al.*, Case No. SA CV 96-1200-GLT (EEx) (C.D. Cal., February 5, 1997) (order granting motion for remand), the district court relied on the Ninth Circuit's decision in this case in remanding the case to state court. The court ruled that "[t]he

(Cont'd)

enormous number of people already enrolled and expected to enroll in Medicare HMOs, the Ninth Circuit's decision likely will generate a flood of litigation in the state and federal courts. Such litigation will undermine severely government efforts to reduce costs and achieve consistent implementation within the Medicare program.

Review by this Court is both appropriate and necessary because the Ninth Circuit's decision plainly creates a split in the circuits concerning the identification of claims "arising under" the Medicare Act, and because the potential negative consequences of this decision are so substantial.

FURTHER REASONS FOR GRANTING THE WRIT

Petitioner Arrowwest Physician Association ("Arrowwest") hereby adopts and incorporates by reference the Petitioners' Reply to Opposition to the Petition for a Writ of Certiorari filed by Aetna Health Plans of California, Inc., Aetna Life Insurance Company, AHP Holdings, Inc., Aetna Health Management, Inc. and Judith Hendrix (collectively "Aetna"). In addition, Arrowwest respectfully submits the following additional arguments in reply to Respondents' Brief in Opposition to the petitions for *certiorari*.

I.

RESPONDENTS HAD "STANDING" IN THE ADMINISTRATIVE PROCESS.

Respondents argue that they had no standing, and therefore no obligation, to pursue the Medicare administrative appeals

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(Cont'd)

state law claims, while predicated on Defendant's initial refusal to provide a [particular procedure], are not 'inextricably intertwined' with the denial of benefits. Plaintiff is not seeking payment for any benefit." Appendix D at 17a. *Minka* is not a wrongful death case, and it does not involve claims by the beneficiary's family.

process. Respondents' Brief in Opposition at 5, 21. Respondents are wrong. As set forth in Arrowwest's Petition for a Writ of Certiorari, the regulations implementing the Medicare HMO appeals process expressly provide that ***the parties to an HMO benefits decision, who have hearing rights and are bound by the administrative decision, include "[t]he legal representative of a deceased enrollee's estate."*** 42 C.F.R. § 417.610 (emphasis added). Respondents completely ignore this provision, which plainly demonstrates that the families of deceased enrollees are subject to the administrative appeals process and are bound by the resulting administrative determinations (subject to judicial review only after exhaustion of administrative remedies; *see* 42 U.S.C. §§ 405(g) and (h), 1395ff and mm). If that were not the case, the regulation would be meaningless. This analysis is not affected by the fact that Respondents are not seeking to recover the actual benefits because payment of the benefits would not adequately compensate their loss. *See Heckler v. Ringer*, 466 U.S. 602, 623 (1984) (plaintiffs' claim was barred even though they were challenging an agency ruling foreclosing recovery of benefits). Respondents also ignore the statutes and regulations providing that ***total denials of benefits*** (*i.e.*, determinations that the amount of benefits due is zero; *see* 42 U.S.C. § 1395ff(b)(1)(C)), including ***denials of emergency services*** (*see* 42 C.F.R. § 417.606(a)), are subject to the administrative appeals process, even though such denials obviously will result in death on some occasions, and thus the relief available will not fully compensate the loss. That is undoubtedly the reason why the regulations expressly apply to the representatives of deceased enrollees and make the administrative appeals process binding upon them.

II.

RESPONDENTS' CLAIMS "ARISE UNDER" THE MEDICARE ACT.

The crux of the Ardarys' claim is that benefits were wrongfully denied. That fact required them to challenge that denial through the Medicare administrative process. Respondents' assertion that "the benefits determination is not, *per se*, at issue" (Respondents' Brief in Opposition at 5) is plainly wrong. Even the most cursory reading of the Ardarys' complaint reveals that the *sine qua non* of their case is the decision by an Arrowwest representative not to authorize what the Ardarys contend was a covered benefit: an airlift transfer to another hospital.[2] As Petitioners (both Arrowwest and Aetna) have emphasized repeatedly, this case cannot be decided without determining whether Cynthia Ardary was entitled to the benefit of the airlift transfer under her Medicare HMO plan. Even the Ninth Circuit's opinion recognized that "their wrongful death complaint is 'predicated on' Arrowest's failure to authorize the airlift transfer. . . ." Appendix A at 9a. Thus, Respondents' claims are indeed "inextricably intertwined" with a benefits determination.

Moreover, as Aetna states in its Reply, an airlift transfer *is* covered by Medicare Part B where medically appropriate. The fact that the plan also may have offered some benefits beyond those covered by Medicare is irrelevant. Aetna's Reply at 7-8. If the transfer had been medically appropriate, then it would have been covered by Medicare; if not medically appropriate, it would not have been covered as a supplemental benefit either. Thus, their claims clearly "arise under" the Medicare Act. Indeed, whether a requested treatment or service was medically appropriate, and therefore subject to coverage, is precisely the kind of determination that is supposed to be made through the Medicare administrative

2. The Arrowwest representative who made the decision was Cynthia Ardary's own cardiologist, who, contrary to Respondents' claim, was *not* an "employee" of Arrowwest.

process, so that the program can maintain some control over what is covered and what is not. The courts certainly should not get involved until the agency at least has had an opportunity to resolve that question itself. This Court should grant review to prevent widespread judicial encroachment on what is supposed to be an agency function.

III.

THE MEDICARE AND ERISA PREEMPTION PROVISIONS MAY NOT BE IDENTICAL, BUT THEY ARE ANALOGOUS; THE LAW IN BOTH INSTANCES PROVIDES THAT SOME TYPES OF CLAIMS RELATING TO HEALTH BENEFITS MAY NOT BE PURSUED IN STATE COURT.

Respondents argue that because the Medicare Act does not contain the same broad preemption language found in ERISA, no aspect of ERISA law can be instructive in this case. Respondents' Opposition Brief at 14-18. That is incorrect. Both ERISA and the Medicare Act, by virtue of their express provisions and judicial interpretation, provide that certain types of claims regarding health benefits cannot be pursued in court. *See Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (ERISA preempted a malpractice claim against a medical consulting company for "precertification review" decisions); *Heckler v. Ringer*, 466 U.S. 602 (1984) (barring claims regarding an agency policy to deny Medicare payments for a particular treatment).

However, contrary to Respondents' contentions, Petitioners never have argued that the Medicare Act preempts all tort claims against providers. Clearly, it does not. Even ERISA, which Respondents' acknowledge has a far broader preemption provision, does not preempt all state law tort claims. Rather, ERISA law distinguishes between ***claims that benefits were wrongfully denied***, which are preempted, and ***claims that the quality of benefits***

actually provided fell below the standard of care (*i.e.*, medical malpractice claims), which are not. *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 355-361 (3rd Cir. 1995). Similarly, the Medicare Act makes clear that denials of Medicare benefits are subject to the exclusive Medicare appeals process. 42 U.S.C. §§ 405(g) and (h) and 1395ff(b). That does not mean that all tort claims against Medicare providers or Medicare HMOs are preempted, only that tort claims predicated on allegedly wrongful ***denials*** of benefits, such as those here, are foreclosed.

Respondents' suggestion that there is no reason to restrict tort suits for wrongful denials of benefits in the Medicare HMO context because "a Medicare HMO has no employee fund to administer" (Respondents' Brief in Opposition at 17) ignores the fact that Medicare HMOs are administering the ***taxpayers'*** funds. As this Court has ruled repeatedly, there is every reason to respect Congress's choice to restrict the remedies available under the Social Security Act generally, and the Medicare Act in particular, in order to ensure the perpetuation of the program as a whole. *See Schweiker v. Chilicky*, 487 U.S. 412, 429 (1988); *Heckler v. Ringer*, 466 U.S. 602, 627 (1984). The courts are not at liberty to provide litigants with remedies that Congress plainly has foreclosed, and Respondents cannot circumvent the will of Congress simply by pleading that the alleged wrongful denial of benefits was "negligent." If the remedies available to Medicare recipients or their survivors where benefits have been denied are inadequate, it is up to Congress to change that, not the courts.[3]

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3. Respondents' further assertion that the Medicare HMO system "has no need of a consistent and orderly administrative structure" (Respondents' Opposition Brief at 17) is absurd. In fact, the Department of Health and Human Services' commitment to a comprehensive administrative review process for Medicare HMOs is demonstrated by the newly released final rule establishing *expedited* appeal procedures for time-sensitive adverse benefits determinations by Medicare HMOs. 62 Fed. Reg. 23368 (April 30, 1997) (to be codified at

(Cont'd)

IV.

RESPONDENTS' DISTINCTIONS OF AUTHORITIES CITED BY PETITIONERS ARE SPECIOUS.

Respondents are wrong to state that Aetna was merely a "provider" in this case (supposedly unlike the situation in *Bodimetric Health Services, Inc. v. Aetna Life & Casualty*, 903 F.2d 480 (7th Cir. 1990)), and therefore that 42 U.S.C. § 405(h) does not apply here. Respondents' Brief in Opposition at 13, 20. Aetna was ***not*** the healthcare provider in this case. As an HMO, Aetna contracted with Arrowwest, a group of physicians (among others), to provide care to its Senior Choice enrollees. Aetna was and is an "eligible organization" authorized to arrange for the provision of covered Medicare services to its Medicare-eligible enrollees. *See* 42 U.S.C. §§ 1395mm(b) (defining "eligible organization") and 1395mm(c)(2)(A) ("[t]he organization must provide to its members enrolled under this section, ***through providers and other persons that meet the applicable requirements of this subchapter*** . . . only those services covered . . . under this subchapter. . . . (emphasis added)). Thus, Respondents' argument that the administrative appeal provisions of 42 U.S.C. § 1395mm(c)(5)(B) do not apply to Aetna (Respondents' Brief in Opposition at 20) flies in the face of the plain wording of the law. The statute expressly states that "eligible organizations" such as Aetna ***are*** parties to administrative proceedings and any subsequent judicial review regarding benefits determinations. Respondents' argument that applying 42 U.S.C. § 405(h) (through § 1395mm(c)(5)(B)) to Medicare HMOs would insulate all Medicare providers from tort

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(Cont'd)
42 C.F.R. § 417). The background information provided in the Federal Register notes that all adverse benefits determinations by Medicare HMOs are subject to the Medicare administrative appeals process, a regulatory determination squarely at odds with the Ninth Circuit's decision here. 62 Fed. Reg. at 23369.

liability (Respondents' Brief in Opposition at 20) is plainly wrong, and the Ninth Circuit was wrong to accept it. (*See* Appendix A to Arrowwest's Petition for a Writ of Certiorari at 12a-13a.)[4]

Respondents' attempted distinction of *Hooker v. U.S. Department of Health & Human Services*, 858 F.2d 525 (9th Cir. 1988), also fails. According to Respondents, *Hooker* is inapplicable here because in that case the family of a deceased beneficiary was "suing the very parties 405(h) forbids actions against: The Secretary, the government and their employees." Respondents' Brief in Opposition at 25. This is another misunderstanding of Medicare law. Under 42 U.S.C. § 1395mm, Medicare HMOs are agents of the Secretary, and their determinations are expressly subject to the Medicare appeals process, including the limited judicial review provisions of § 405(h). 42 U.S.C. § 1395mm(c)(5)(B); *see also* 62 Fed. Reg. at 23369 (after exhaustion of procedures for reconsideration and Administrative Law Judge hearings, enrollees dissatisfied with adverse Medicare HMO benefits determinations "may pursue the same administrative and judicial review processes that are available to beneficiaries in fee-for-service. Thus, beneficiaries enrolled in HMOs . . . have appeal rights equivalent to those available in the fee-for-service program"). Therefore, *Hooker* manifestly is ***not*** distinguishable on the basis of the identity of the defendants. Similarly, the *Hooker* court's purported failure to distinguish *Jiminez-Nieves v. United States*, 682 F.2d 1 (1st Cir. 1982) is meaningless. That case (concerning the government's liability for the consequences of a key-punch error) ***did not involve any determination of what benefits were owed***, and thus it is entirely irrelevant to the Ninth Circuit's holding in *Hooker* and to this case.

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4. Respondents' and the Ninth Circuit's attempt to rely on legislative intent language from this Court's decision in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 680 (1986) (*see* Respondents Brief in Opposition at 15-16 and Appendix A at 12a), is misplaced in light of the clear direction from Congress that ***all denials*** are subject to the administrative review process, not merely "amount determinations." 42 U.S.C. § 1395ff(b).

Unquestionably, *Hooker* applies to this case. In *Hooker*, the plaintiffs were the surviving wife and children of a deceased social security disability benefits recipient. The plaintiffs brought state law tort claims against the government and various government employees individually, alleging that their termination of the decedent's disability benefits had led to his suicide. The Ninth Circuit held that the plaintiffs' claims were barred by Section 405(h), "***expressly reject[ing] the argument plaintiffs make here, that claims for damages caused by the Secretary's allegedly negligent acts do not 'arise under' the Act.***" 858 F.2d at 529 (emphasis added). According to the *Hooker* court, the plaintiffs' state law tort claims were "merely a disguised dispute with the Secretary." *Id.* at 530. The court explained:

> Plaintiffs contend that [defendant] negligently evaluated the medical evidence before it and wrongly concluded that Hooker was no longer disabled. This claim seeks an adjudication by a federal court that Hooker was indeed disabled within the meaning of the Act. Congress envisioned "just this type of claim," however, in creating an administrative remedial scheme by which an aggrieved person may contest the termination of benefits.

Id. at 529. In this case, just as in *Hooker*, plaintiffs allege that a negligent denial of benefits led to the death of their loved one. And in this case, just as in *Hooker*, allowing plaintiffs to proceed with this lawsuit would require a judge (in this instance a state court judge) to decide whether the disputed benefit of an airlift transfer was medically appropriate and subject to coverage under the circumstances. As the Ninth Circuit correctly recognized in *Hooker*, Congress has determined that this is not an appropriate or permissible determination for a judge to make.

CONCLUSION

All three branches of our government have made clear that Medicare HMO contractors are no different than the government itself with respect to their Medicare benefits determinations, which must be challenged through the administrative appeals process prescribed by § 405(h). That scheme is among the bargained-for inducements for otherwise private health insurers to assist the federal government in bringing managed care to the Medicare program. The Ninth Circuit's contrary holding undermines not only the text but also the intent of the law establishing the Medicare managed care program: to create and encourage public-private partnership to assure cost-effective, quality health care to millions of Medicare beneficiaries.

Review also is urgently needed to resolve the split in the circuits concerning what kinds of claims "arise under" the Medicare Act, because the proliferation of managed care will cause claims against Medicare HMOs to multiply rapidly.

For all the foregoing reasons, the petitions for writ of *certiorari* should be granted.

Respectfully submitted,

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APPENDIX D — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA FILED FEBRUARY 4, 1997

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

Case No. SA CV 96-1200-GLT (EEx)

Calendar Item #9

GEORGE MINKA,

Plaintiff,

vs.

PACIFICARE OF CALIFORNIA dba SECURE HORIZONS and PACIFICARE HEALTH SYSTEMS, PACIFICARE SYSTEMS INC., A DELAWARE CORPORATION, SHARP MISSION PARK MEDICAL GROUP, and DOES 1 to 100, inclusive

Defendants.

ORDER GRANTING MOTION TO REMAND

Plaintiff's Motion to Remand is GRANTED.

DISCUSSION

If at any time before the final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded. 28 U.S.C. § 1447(c).

Appendix D

Plaintiff moves to remand this case to state court for lack of subject matter jurisdiction because his causes of action do not "arise under" the Medicare Act ("Act") pursuant to *Ardary v. Aetna Health Plan of California, Inc.*, (9th Cir. 1996) 98 F.3d 496. The Court agrees with Plaintiff.

The Ninth Circuit in *Ardary* recently ruled the Medicare Act did not preclude state law claims against private Medicare providers where claims did not seek recovery of Medicare benefits, but rather sought compensatory and punitive damages resulting from tortious conduct of the providers. *See Ardary*, 98 F.3d 496. The dispositive question in determining whether federal jurisdiction exists is whether the claim "arises under" the Act. *Ardary*, 98 F.3d at 496; *see also Heckler v. Ringer*, (1984) 466 U.S. 602, 614-615, 104 S.Ct. 2013, 80 L.Ed.2d 622.

For a determination that a claim does not "arise under" the Act, the complaint must not "include any claims in which 'both the standing and the substantive basis for the presentation' of the claims is the Act.["] *Ardary*, 98 F.3d at 499 (citing *Heckler*, 466 U.S. at 615). Therefore, to deny this court jurisdiction, Plaintiff's standing to assert claims must rest on state common law, not the Act, and the state claims must not be "inextricably intertwined" with the denial of benefits. *Id.*

Plaintiff's complaint alleges sixteen causes of action against Defendants: breach of contract, bad faith breach of contract, fraud, specific performance, intentional and negligent interference with contractual relations, intentional and negligent infliction of emotional distress, intentional and negligent interference with physician/patient relationship, negligence, elder abuse, civil conspiracy, declaratory relief, and injunctive relief. Standing for these claims is premised on state common law theories and not the Act.

Moreover, the state law claims, while predicated on Defendant's initial refusal to provide a TMR, are not "inextricably intertwined" with the denial of benefits. Plaintiff is not seeking payment for any benefit. In fact, Plaintiff has already received the requested medical treatment. Plaintiff's claims are based on common law tort and contract principles, not the Act.

There is a strong presumption that Congress does not intend to preempt state law causes of action with a federal statute. *Ardary*, 98 F.3d at 501. There is nothing in the Act's legislative history to suggest it was designed to abolish all state remedies which might exist against a private Medicare provider for torts committed during its administration of Medicare benefits pursuant to a contract with HCFA. *Id.*

Because the state law claims brought by Plaintiff do not "arise under" the Act, the exclusive administrative procedures outlined for resolution of benefit determinations do not preempt Plaintiff's complaint.

DISPOSITION

Plaintiff's motion to remand is GRANTED.[1]

DATED: 2-4-97

s/ Gary L. Taylor
GARY L. TAYLOR
UNITED STATES DISTRICT JUDGE

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1. Since remand is granted, the court does not reach defendants' motion to dismiss, which can now be asserted in state court.